

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER St Catherine of Siena		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Ryerson Avenue Caldwell, NJ 07006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 5/26/26 at 5:25 PM, in the presence of Food Service Director (FSD) the surveyor observed the following: 1. The Dietary Aide (DA#1) was observed wearing with large hooped earrings in the kitchen. DA#1 stated they were not aware they could not wear large earrings in the kitchen. The FSD stated they would provide education the entire kitchen staff. 2. On a 4 shelf, dish storage rack, the surveyor observed a dust-like build up on each shelf. The FSD stated the shelves would be cleaned immediately. 3. In the cooking area, on the 6-range stovetop the surveyor observed burnt on food-like particles and a blackish grease-like substance on the griddle. The FSD stated there is a cleaning schedule and the equipment would be thoroughly cleaned. 4. In the walk-in refrigerator, the surveyor observed a dust-like substance on the fan covers. The FSD stated they would contact maintenance to clean the fan covers. 5. In the dry storage room, the surveyor observed a thermometer that read 80 degrees Fahrenheit (F). The FSD stated they are aware the dry storage room should be 70F or lower and would speak to maintenance about getting additional fans and an air conditioning unit. On 5/28/26 at 12:20 PM, the Licensed Nursing Home Administrator provided the surveyor with multiple facility policies. The uniform policy with an approved date of 5/26/26 revealed under the procedures section, 4. Jewelry, open-toe shoes, and long nails are prohibited. The cleaning of equipment policy with an effective date of 5/28/26 revealed under the cleaning frequency, Every 4 hours, surfaces in continuous use must be sanitized to stop bacterial growth. Daily: thoroughly wipe down large appliances (ovens, stovetops, reach-in refrigerators handles) and wash floor mats. The dry storage policy with an effective date of 7/2024 revealed under the procedure section, Storage rooms may retain an environment of good ventilation and temperature between 50F and 70F. On 5/28/26 at 12:42 PM, the surveyor met with the LNHA and Director of Nursing to review concerns found during the survey. The LNHA stated they were addressing all kitchen concerns and corrective actions are being put in place. On 5/29/26 at 12:01 PM, the surveyor met with the LHNA, DON, Infection Preventionist (IP) and the Prioress for the exit conference. No further pertinent information was provided. NJAC 8:39-17.2(g)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. repeat deficiency Based on observation, interview and review of pertinent facility documentation, the facility failed to ensure Feeding Assistance staff were assigned to feed residents that did not have complex diets (the physical/mechanical texture of the food). This deficient practice was identified for 2 of 3 residents reviewed (Resident # 17 and Resident # 28) and was evidenced by the following: 1. A review of Resident #17's admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Parkinsons disease (a progressive nervous system disorder that affects movement), Epilepsy (a group of neurological disorders characterized by seizures), unspecified dementia (Loss of memory, language, problem solving that interfere with daily living) and vision loss in both eyes. A review of Resident #17's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 00 (0 of 15), which indicated severe cognitive impairment. Further, section K revealed the resident was on mechanically altered diet. A review of the physician order set (POS) revealed an order dated 10/28/25, mechanical soft texture, regular diet. A review of the care Individualized Care Plan (ICP) revealed a focus of nutritional risk related to shakes and tremors exacerbation of Parkinson's disease, dated 1/3/24 and revised on 8/21/25. It further revealed an intervention dated 10/29/25 and revised on 3/13/26, resident needs to be encouraged to eat and fed all meals by feeding assistance. A review of the medication administration record (MAR) revealed an order dated 5/13/26, that the resident was fed all meals and snacks, the resident forgot how to feed himself. A review of the Speech evaluation revealed clinical impression that oral motor structures and functions appear adequate for the purpose of safety tolerating mechanical soft diet with thin liquid diet. 2. A review of Resident #28's admission Record face sheet reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, unspecified dementia, severe anxiety. A review of Resident #28's most recent MDS reflected that the resident had a BIMS score of 3 of 15 indicating severe cognitive impairment. Further, section K revealed the resident had a swallowing disorder and was prescribed a mechanically altered diet. A review of the POS revealed an order dated 2/15/26, for pureed texture, regular diet, and the resident to only be fed when adequately alert. A review of the care ICP with an initiated date of 10/8/24 and revised on 3/16/26 revealed a focus of nutritional risk secondary to poor sleeping habits causing increased lethargy during the day, The ICP further revealed an intervention dated 2/18/26 that a speech therapy evaluation was done and the resident's diet was downgraded to pureed diet. A review of the MAR revealed an order dated 5/27/26, for feeding assistance with every meal and snack as necessary every shift. A review of the speech evaluation revealed a clinical impression that revealed the comprehensive findings were suggestive that the resident presents with relatively severe dysphagia that affected the oral and the pharyngeal phases. Further review revealed that the recommendation were for a pureed diet with thin liquids under aspiration precautions with nursing staff to feed residents only when adequately alert. On 5/26/24 at 12:42 PM, in the presence of the survey team, the surveyor interviewed the Director of Nursing (DON), who stated that she is the educator for the feeding assistances and the residents on the list provided by the facility were accurate for the feeding assistance assignments. The list consisted of 3 residents including resident #17 and #28. On 5/28/26 at 09:30 AM, the surveyor interviewed the DON, who stated that the feeding assistance helps the residents that cannot feed themselves. She further stated that the feeding assistance are not licensed to provide nursing assistance or are a professional (continued on next page)		

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse and could not assist in an emergency. The DON acknowledged and agreed that there was a safety concern with the feeding assistants assisting residents with an altered or complex diet. On 05/29/26 at 10:49 AM, in the presence of the survey team, the LNHA stated that she did not have any further responses related to the concern. A review of the facility provided policy titled, Paid Feeding Assistance with an effective date of 11/2025, included the nursing staff will identify residents who are approved to receive dining assistance by the paid feeding assistant. Eligible residents are without complicated feeding problems such as, but not limited to, difficulty swallowing. Resident criteria- the feeding assistant provides only assistance for those residents who have been identified as needing assistance and are without complicated feeding problems. A review of the facility provided policy titled, Paid Dining Assistance training with an effective date of 2025, revealed patient restrictions. Dining assistances in New Jersey cannot feed complex residents. N.J.A.C. 8:39-17.3(c)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within the resident's reach (Resident #25). This deficient practice was identified for 1 of 28 residents reviewed for accommodation of needs (Resident #25, and was evidenced by the following: On 5/28/26 at 10:10 AM, the surveyor observed Resident #25 in their bed with the call bell at the bottom of the bed, wrapped around the bed frame not within the resident's reach. The surveyor reviewed the medical record for Resident #25. A review of the admission Record reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to; chronic kidney disease, dementia, and a history of falls. A review of the quarterly Minimum Data Set (MDS) an assessment tool, dated 4/20/26, indicated the resident had severe cognitive impairment and required staff assistance for activities of daily living (ADLs). A review of Resident #25's Care Plan (CP) included a focus area that the resident was at high risk for falls, with interventions that included but were not limited to: ensure the resident's call light is within reach. ensure the resident receives prompt response to all requests for assistance initiated 4/9/23. On 5/28/26 at 10:20 AM, the surveyor showed the above observation to the Registered Nurse assigned to Resident #25. The RN acknowledged that the call bell should have been left within the resident's reach. On 5/28/26 at 12:40 PM, the surveyor discussed the above observations and concerns with the Director of Nursing (DON) and the Licensed Nursing Home Administrator. The DON acknowledged that call bells should be within reach of all residents. On 5/29/26 at 11:45 AM, during a telephone interview with the Certified Nursing Assistant (CNA) assigned to Resident #25's care on 5/28/26 day shift (7AM-3 PM) confirmed that she should have placed the call bell within the resident's reach. On 5/29/26 at 12:02 PM, no further information was provided. NJAC 8:39- 31.8 (c)(9)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) ensure that a specialty low air loss mattress was accurately set and monitored according to the resident's weight for 1 of 3 residents (Resident #25) and b.) failed to provide a resident with a wound the necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcer development for 1 of 2 residents reviewed (Resident #4). This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents and immediately after glove removal. In addition, when cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, and this should be done outside the water when rubbing your hands, then rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take approximately 20 seconds. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. a. On 5/28/26 at 10:10 AM, the surveyor observed Resident #25 in bed and a specialty mattress in place. The resident's air mattress pump was set at 250 lbs. The surveyor reviewed the electronic medical record (E-mar) for Resident #25. A review of the admission Record (AR) reflected that Resident #25 was admitted to the facility on [DATE] with diagnoses that included but were not limited to; chronic kidney disease (a condition where the kidneys are damaged and gradually lose their ability to filter waste and excess fluids from your blood), dementia (a decline in mental ability), and a history of falls. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 4/20/26, reflected that the resident had severe cognitive impairment. A review of the current Physician Order Summary Report (OSR) reflected a Physician's Order (PO) for an alternating pressure air mattress with pump; to check that the pump is set on the correct weight with a start date of 7/1/25. A review of the current Treatment Administration Record (TAR) included an alternating pressure mattress that was in place and to monitor every shift; check for foam protectors in place on pump hangers, check to ensure air pump is operational, and that the pump is set at the correct weight with a start date of 7/1/25 and signed by nurses, which indicated it was being monitored. A review of the Vital Signs reflected the last weight was 143.8 pounds (lbs.) on 5/27/26. A review of Resident #25's Care Plan revealed a focus that included the resident has potential for impairment to skin integrity related to fragile skin, incontinence, need for assistance with positioning, toileting, and hygiene, with interventions that included but were not limited to: Air Mattress in place. On 5/28/26 at 10:20 AM, the surveyor showed the Registered Nurse (RN) assigned to Resident #25 the gauge setting on the specialty mattress. The RN acknowledged that the setting was set to 250 lbs. and stated it should have been set to the resident's weight of 143.8 lbs. The RN confirmed that the specialty mattress had been ordered to (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent and assist in preventing pressure ulcers and stated that maintaining the correct weight setting was important to ensure the device's effectiveness. On 5/28/26 at 12:40 PM, the surveyor discussed the above observations and concerns with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). A review of the facility's Pressure Relieving Devices dated 2024 reflected .According to the National Pressure Injury Advisory Panel (NPIAP) support surface standards initiative, Low Air Loss (LAL) is defined as a support surface construction that uses a flow of air to assist in pressure redistribution and may assist in managing the heat and humidity of the skin .Indications for use .Residents at high risk for pressure injuries or with a current pressure injury unable to be adequately repositioned . b. On 5/26/26 at 7:30 PM, the surveyor observed Resident #4 in their room, seated in a wheelchair.The surveyor reviewed the E-mar for Resident #4. A review of the AR reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to: diabetes mellitus (high blood sugar); and congestive heart failure (a serious progressive condition where the heart muscle becomes weak and is unable to pump efficiently, which causes the fluid to back up and accumulate in the lungs, legs, and abdomen). A review of the most recent MDS, dated [DATE], reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating an intact cognition. A review of the current OSR dated 5/28/26 reflected a PO to cleanse the right shin wound with Normal Saline Solution (NSS), apply calcium alginate (a highly absorptive material used for moderate to heavy draining wounds), apply an ABD pad (used for draining wounds), and secure with Kling (gauze that provides soft cushioning) two times a day. A review of the CP identified a focus area indicating the resident had a skin impairment, with interventions that included, but were not limited to, wound care: cleanse with NSS, apply calcium alginate, and secure with bordered dressing. On 5/28/26 at 10:55 AM, the surveyor observed the RN perform a wound treatment to Resident #4's lower leg. The RN placed three paper towels on top of the resident's over-bed table (OBT) without disinfecting it. The RN assembled the needed supplies from the treatment cart and placed them on the OBT in the resident's room. Among the supplies were 2 ABD pads, 4 normal saline solution bullets, a 2x2 Calcium Alginate dressing, Kling gauze wrap, and tape.The surveyor observed the RN perform hand hygiene. The RN applied soap to her hands and immediately placed them under running water without first lathering.The RN cleansed the wound, applied the calcium alginate dressing, and wrapped the wound with the Kling. The RN wrote directly on the dressing after it was applied rather than labeling it prior to application.The surveyor observed the RN perform hand hygiene. The RN applied soap to her hands and immediately placed them under the running water without first lathering. The surveyor discussed the breaches in infection control with the RN, who acknowledged that she should have lathered her hands for 20 seconds before placing them under the water and should have initialed and dated the dressing prior to its application. On 5/28/26 at 12:40 PM, the survey team discussed the above observations and concerns with the DON and LNHA. A review of the facility's Skin Integrity/Wound Care policy dated 2/2025 reflected .The Nursing staff is knowledgeable and competent in providing basic prevention, assessment, and treatment to Residents with wounds. On 5/29/26 at 12:02 PM, no further information was provided. NJAC 8:39-19.4(a); 27.1 (a)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, and review of facility policies, it was determined the facility failed to provide new fall interventions following a residents fall, accurately code the Minimum Data Set ((MDS), an assessment tool used to facilitate the management of care), follow a Physician Order (PO) for residents who had a history of falls. This deficient practice was identified for 2 of 2 residents (Resident #25 and #27) reviewed for falls. The deficient practice was evidenced by the following: On [DATE] at 6:39 PM, the surveyor observed Resident #27 in bed with the eyes closed. Resident #27's bed was observed in the lowest position to the floor and had a partial bedrail (a safety device attached to the sides of a bed, designed to prevent patients from falling out of bed and to assist with mobility.) On [DATE] at 7:29 PM, the surveyor reviewed the electronic medical record (E-mar) for Resident #27. A review of the resident's Face sheet (FS) (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to: dementia (decline in cognitive function, affecting memory, thinking, and behavior), Parkinsons disease (a progressive neurological disorder that primarily affects movement) and urinary incontinence (involuntary leakage of urine). A review of the quarterly MDS, with a reference date [DATE] reflected that the resident had a Brief Interview for Mental Status (BIMS) score 12 of 15, indicating that the resident had moderate cognitive impairment. The MDS further revealed that Resident #27 has had a fall since admission. A review of Resident #27's care plan report (CPR) revealed a care plan (CP) for falls with a revision date of [DATE] and a focus area, Resident is at risk for falls related to Parkinsons and History of falls. The CP's last initiated and revised interventions was on [DATE], The resident uses fall mat next to bed while in it, ensure this device is in place as needed. On [DATE] at 9:13 AM, the Director of Nursing (DON) provided the surveyor with fall investigations from Resident #27 for the past 18 months. The investigation revealed the resident had two previous falls on [DATE] and [DATE]. A review of Resident #27's quarterly MDS from with a reference date of [DATE] revealed the resident's fall in 6/2025 was not coded. On [DATE] at 12:21 PM, the surveyor interviewed the DON, who stated care plans should be updated with new interventions following a residents fall as well as the MDS for [DATE] had failed to capture to Resident #27's fall from [DATE] On [DATE] at 12:30 PM, the Licensed Nursing Home Administrator provided the surveyor with multiple facility policies. The MDS-Comprehensive policy with a revised date of 4/2025 revealed, the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity. The Fall Management policy with a revised date of 2/2025 revealed under the procedure section, 5. Interventions may be implemented as Nursing and Therapy deems appropriate to the individual resident's needs.8. The Interdisciplinary Committee Team will meet to discuss the resident's assessments/observations and the appropriateness of interventions. b. On [DATE] at 10:10 AM, the surveyor observed Resident #25 in bed with their eyes closed. The surveyor observed a landing mat folded against the wall not on the floor next to the Resident's bed. The surveyor reviewed the e-MAR for Resident #25. A review of the AR reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to; chronic kidney disease (a condition where the kidneys are damaged and lose their ability to filter waste and fluids from the blood) dementia (a decline in mental ability) and a history of falls. A review of the quarterly MDS dated [DATE], indicated the resident had severe cognitive impairment, and required staff assistance for activities of daily living (ADLs). A review of the current PO for Resident #25 included a PO dated [DATE], floor mat to left side of bed every shift for safety while the resident is in bed. A review of Resident #25's CP included a focus area that the resident was at high risk for falls, with interventions that included but were not limited to: fall mat in place. On [DATE] at 10:20 AM, the surveyor showed the above observation to the Registered Nurse assigned to Resident #25. The RN acknowledged that the floor mat should have been placed to the left of the resident's bed per the PO, and confirmed that the resident was at high risk for falls. On [DATE] at 12:40 PM, the surveyor discussed the above observations and concerns with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON confirmed that the mat should have been placed to the left of Resident #25's bed per the PO. On [DATE] at 11:45 AM, during a telephone interview with the Certified Nursing Assistant (CNA) assigned to Resident #25's care on the day shift of [DATE] confirmed that the floor mat should have been placed on the left side of the resident's bed in accordance with the resident's fall prevention interventions. The CNA acknowledged that the floor mat was not in place and stated that she may have forgotten to position it properly. On [DATE] at 12:01 PM, the surveyor met with the LHNA, DON, Infection Preventionist (IP), and the Prioress for the exit conference. No further pertinent information was provided. NJAC 8:39-27.1(a); 31.4(a); 33.1(d)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and review of facility policy it was determined that the facility failed to follow Physician Orders (PO), individualized care plan (ICP), and facility policy by not providing a privacy bag for a resident with an indwelling urinary catheter (IUC). This deficient practice was noted for 1 of 1 resident's reviewed with IUC, (Resident #6). This deficient practice was evidenced by the following: On 5/26/26 at 6:24 PM, the surveyor observed Resident #6 in bed with an IUC (flexible tube that is inserted through the urethra into the bladder to drain urine) bag observed connected to bedrail without a privacy bag. Resident #6 stated they do not recall having a privacy bag for their IUC. On 5/26/26 at 6:49 PM, the surveyor reviewed the electronic medical record (E-mar) for Resident #6. A review of the resident's Face sheet (FS) (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to: urinary tract infection (an infection in any part of the urinary system), retention of urine (a condition where your bladder does not empty all the way or at all when you urinate), and urinary incontinence (involuntary leakage of urine). A review of the quarterly Minimum Data Set ((MDS), an assessment tool used to facilitate the management of care), with a reference date 5/5/26 reflected that the resident had a Brief Interview for Mental Status (BIMS) score 15 of 15, indicating that the resident had normal cognitive function. The MDS also noted that Resident #6 had an indwelling catheter. A review of the Physician Orders Summary (POS) revealed a Physician Order (PO) dated 3/26/25, please do not leave suprapubic catheter supplies and dressing out in view. A review of Resident #6's ICP revealed a focus area, resident had a suprapubic catheter due to long time urinary retention and an intervention, please make sure the tube is not twisted, and the bag is always covered. On 5/27/26 at 10:35 AM, the surveyor had an additional observation of Resident #6 in bed with their IUC drainage bag not in privacy bag. On 5/27/26 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN#1) who stated Resident #6 has a IUC for urinary incontinence but was unable to explain why Resident #6 did not have a privacy bag as per PO and ICP. On 5/28/26 at 11:11 AM, the surveyor interviewed the Director of Nursing (DON), who stated all residents with IUC should have a privacy bag. On 5/27/26 at 11:28 AM, the DON provided the surveyor with a facility policy, Indwelling Catheter Maintenance Care with a revised date of 1/2025. The procedures portion of the policy revealed, 4. Position urinary bag off the floor at all times and cover with a privacy bag when in bed and in wheelchair. On 5/28/26 at 12:42 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and DON to review concerns found during the survey. The DON stated Resident #6 now has an IUC privacy bag and corrective actions are being put in place. On 5/29/26 at 12:01 PM, the surveyor met with the LNHA, DON, Infection Preventionist (IP) and the Priorress for the exit conference. No further pertinent information was provided. NJAC 8:39-19.4 (a)4,5,6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER St Catherine of Siena		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Ryerson Avenue Caldwell, NJ 07006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, it was determined that the facility failed to follow a Physician's Order (PO) for an Oxygen (O2) dependent resident and failed to include or revise the person-centered Comprehensive Care Plan (CCP) for O2 therapy, in accordance with professional standards of practice. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11, Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11, Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On [DATE] at 6:55 PM the surveyor observed Resident #20 in bed with their eyes closed. Resident #20 was observed receiving O2 via nasal cannula (NC) (medical device to provide supplemental oxygen therapy to people who have lower O2 levels). The surveyor observed the setting on the O2 supply device to be between 2.5 and 3 liters per minute (lpm). The surveyor asked the Licensed Practical Nurse (LPN) on duty about Resident #20's oxygen therapy. The LPN stated that it is given at 4 lpm. On [DATE] at 11:07 AM, the surveyor Observed Resident #20's oxygen settings. The setting was observed as 3 lpm. On [DATE] at 11:30 AM, the surveyor reviewed Resident #20's electronic medical record (e-MAR) which revealed the following: The surveyor reviewed Resident #20's admission Record (an admission summary) which revealed that the resident had been admitted to the facility with diagnoses that included but were not limited to; respiratory arrest (stopping of breathing), dependence on supplemental oxygen, and essential hypertension (high blood pressure). A review of the Quarterly Minimum Data Set Assessment (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [DATE], revealed that the resident had a score of 0 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. The MDS also reflected that the resident received O2 therapy. A review of the [DATE] PO for Resident #20 included a PO dated [DATE], O2 at 2-4L via n/c for sob every shift for shortness of breath, a PO dated [DATE], Check if O2 in use whether prn or continuous that concentrator matches physician's orders, every shift for supplemental O2 use, a PO dated [DATE], O2 via n/c 4L to maintain psO2 above 90%. A review of the [DATE] electronic medication administration record (eMAR) revealed the [DATE] and [DATE] orders but did not reflect the [DATE] order. The eMAR did not reveal any documentation for O2 saturation (levels of oxygen in the blood) readings. A review of the [DATE] electronic treatment administration record (eTAR) did not reveal any of the orders. The eTAR did not reveal any documentation for O2 saturation readings. The EMR revealed, under vitals, that the last time O2 saturation was recorded [DATE]. Resident #20's Care Plan Report (CPR) revealed a personalized care plan with a focus statement that Resident #118 is on Hospice services. A focus statement that the resident has dementia with an intervention of Oxygen Settings: O2 via as dx by Hospice, revised [DATE]. The CPR did not reveal any focus for Oxygen use (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER St Catherine of Siena		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Ryerson Avenue Caldwell, NJ 07006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or therapy. The surveyor reviewed the facility policy titled Oxygen Administration, dated 12/2023, provided by the LNHA. The policy reflected under Purpose: Administer oxygen therapy in accordance with the attending physician's orders. The surveyor reviewed the facility policy titled Comprehensive Care Plan, dated 3/2024, provided by the LNHA. The policy reflected under 3.i. Reflect currently recognized standards of practice for problem areas and conditions. 5. team is responsible for periodic review and updating of care plans. On [DATE] at 12:42 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) for concerns regarding Resident #20's O2 therapy. The surveyor asked the DON about the conflicting orders for oxygen administration. The DON stated that the older order should have been discontinued and a separate order for oxygen saturation included. The surveyor asked the DON if oxygen use should have a separate focus in the CCP. The DON stated yes, there should be one and it should be clear and in line with the Hospice Care Plan. On [DATE] at 10:32 AM, the survey team met with the LNHA and DON for responses to concerns. The facility did not provide any further pertinent information. NJAC 8:39-11.2(b); 27.1(a)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER St Catherine of Siena		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Ryerson Avenue Caldwell, NJ 07006	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, it was determined that the facility failed to ensure that all certified nursing assistants (CNA) received 12 hours of mandatory in-service training as required annually. This deficient practice was identified for 3 of 5 CNA files reviewed and was evidenced by the following: A review of the in-service records for 5 randomly selected CNAs revealed that 3 of 5 CNAs did not have the required 12 hours of annual in-service training by their anniversary date. 1. CNA #1 had a hire date of 3/14/2024 and completed 11 hours, 12 minutes of training. 2. CNA #2 had a hire date of 10/24/2024 and completed 6 hours of training. 3. CNA #3 had a hire date of 12/5/2011 and completed 11 hours, 42 minutes of training. On 05/28/26 at 11:27 AM, the surveyor reviewed the in-service training tracking forms for the 3 CNAs with the Infection Preventionist (IP), who was also the Staff Educator. The IP stated that the 3 CNAs did not meet the annually required 12 hours of in-services. On 5/28/26 at 12:45 PM, the surveyor team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to convey their concerns and findings. The LNHA and DON both acknowledged and agreed that the CNA's did not meet the 12 hours of required education. On 5/29/26 at 10:30 AM, the LNHA and DON had no further information to provide. A review of a document job description, CNA revealed a requirement of CNA certification that is active and in good standing with the state registry. A review of nursing policy and procedures, dated 1/15/2025, titled Education of Nursing Staff revealed our facility has scheduled required 12 hours mandatory In-Service training for the nurse aids (CNA). staff in-service training to be completed yearly. Resourced by the State Operations Manual (SOM). NJAC 8:39-43.17(b)		